

WIC MEDICAL REFERRAL
PREGNANT, BREASTFEEDING AND NONBREASTFEEDING POSTPARTUM WOMEN

Completion of this form is voluntary. Personally identifiable information is used to determine WIC services (e.g., certification / enrollment and food package issuance) and may be disclosed to others only as allowed by state and federal laws.

INSTRUCTIONS: To facilitate WIC services (certification and food package issuance) for your WIC-eligible patient, fill in the blanks and check the boxes, as appropriate, and return this form to the WIC Project indicated at the bottom of the page.

Patient's First and Last Name _____ Birthdate _____

Address _____ Telephone _____

ALL WOMEN

Present weight _____ Hct _____ %
Present height _____ and/or
Hgb _____ gm
Date taken _____ Date taken _____
Vitamin / Mineral Rx _____

PREGNANT

E.D.D. _____
Weeks gest. _____
Prepreg. weight _____

POSTPARTUM

Delivery date _____
Prepreg. weight _____
Weight gained _____

ALL WOMEN

Current nutrition-related health problems

- ☐ food allergy or intolerance, specify _____
☐ recent major surgery, trauma, or burns, specify _____
☐ infectious disease in last 6 months:
☐ pneumonia ☐ tuberculosis ☐ HIV or AIDS ☐ meningitis ☐ parasitic infection
☐ nutrition-related chronic disease, genetic or central nervous system disorder, or other medical condition, specify: _____

Obstetrical history in any previous pregnancy (if currently pregnant) or most recent pregnancy (if currently postpartum)

- ☐ gestational diabetes ☐ large for gestational age infant
☐ low birth weight or preterm infant ☐ fetal or neonatal death
☐ infant with nutrition-related birth defect, specify _____

PREGNANT WOMEN - Current nutrition-related health problems

- ☐ gestational diabetes ☐ hyperemesis gravidarum
☐ pregnancy-induced hypertension ☐ fetal growth restriction

MEDICAL NUTRITIONAL PRESCRIBED

Ensure: ☐ Regular ☐ Fiber ☐ Glucerna ☐ Glucerna OS ☐ High Calcium ☐ High protein ☐ Light ☐ Plus ☐ Plus HN
Boost: ☐ Regular ☐ Fiber ☐ Plus ☐ High Protein ☐ Breeze
Sustacal: ☐ Regular ☐ Plus

Intended length of use _____

Additional Diagnoses / Health Concerns / Diet Orders

SIGNATURE - Health Care Provider _____ Date Signed _____
(Physician, physician assistant, or advanced practice nurse prescriber signature is required for prescription of a medical nutritional.)

Medical Office / Clinic _____

Address _____ Telephone _____

LOCAL WIC PROJECT: